Mitigation in Sentencing

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In the eyes of many, substance abuse is a matter of personal poor judgment in decision making. In spite of significant popular and scientific literature suggesting that addiction is a condition that has at least some organic and genetic inputs, having a drug or alcohol problem still equates with having a character deficiency. The law reflects this not uncommon perspective in that "being under the influence" of mind-altering substances is not exculpatory unless involuntary ingestion is involved. Furthermore, as is seen below, substance abuse may lead to enhancement of sentence severity. However, substance abuse has also been mitigating for sentencing purposes, ranging from an explicit affirmative defense in California of "diminished actuality" to nebulous so-called "wastebasket" mitigation clauses that permit the defendant to raise any factors of possible consequence. Forensic evaluation focused on the sentencing phase thus takes place in a complex and often uncertain legal context.

Statutory and Case Law Relative to Substance Abuse and Mitigation in Sentencing

Two major levels of consideration pertain when it comes to sentencing schemes. One involves state codes and the case law that defines and guides their implementation by judges. The second is the federal law and a very special ongoing operation that has created a complex but not particularly flexible decision-making process. Aspects of how these levels operate with respect to substance abuse, particularly methamphetamine abuse, and sentencing are detailed below.

State Codes and Cases

In the state sentencing processes, somewhat greater potentials for mitigatory findings are evident. Cases in Ohio from 1997 to the present that have had appellate review were accessed. Table 11.1 provides information regarding the types of cases, issues involved, and outcomes.

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Table 11.1 Methamphetamine and Sentencing: Ohio Appeals 1996–2002 Cases

Citation	Type	Major Issue	Outcome
State ex rel, Wright v. Ohio Adult Parole Authority 75 0S3d 82 661 N.E. 2d728, 1996	Revocation of conditional release	Restrictions in search and seizure; under prior precedent unreasonably obtained evidence not admissible	Evidence obtained unreasonably is admissible
State v. Cossin 110 Ohio App. 3d79673 N.E. 2d 647, 1996	Revocation of conditional release	Use of probationer's statements as evidence	*Miranda* not required; statements admissible
State v. Hawkins 120 Ohio App. 3d277 697 N.E. 2d 1045, 1997	Suppression of evidence	Appellant claimed search warrant not adequate	Trial court upheld
State v. Perry 1997 Ohio App. LEXIS 4309, 9/15/97	Suppression of search evidence	Defendant claimed he had ingested methamphetamine and was therefore incompetent to permit the search	Trial court upheld
In re Wilds 997 Ohio App. LEXIS 4934, 10/24/97	Custody case	Appellant felt he should have been able to extend hearing and given custody in spite of his drug convictions	Trial court upheld
In re Josslin 1998 Ohio App LEXIS 2008, 5/4/98	Custody case	Appellant wanted custody, which had been given to her sister and husband due to neglect and violence with methamphetamine use	Trial court upheld
State v. Robinette 80 Ohio St. 3d 234 685 N.2d 762, 5/13/98	Possession of methamphetamine	Defendant consented to car search; methamphetamine found; defendant claimed lack of knowledge and therefore invalid consent	Trial court upheld
State v. Trumbull 1998 Ohio App. LEXIS 4268, 9/17/98	Possession of methamphetamine	Defendant agreed to search then later said he didn't know he had a choice; methamphetamine found	Trial court upheld

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State v. Wise 1998 Ohio APP. LEXIS 5121, 10/1/98	Possession of methamphetamine	Defendant stated search exceeded scope of warrant; methamphetamine found	Trial court upheld
State v. Signs 1998 Ohio App. LEXIS 5468, 11/20/98	Possession and trafficking in methamphetamine	Defendant originally pled no contest; possessed and transported methamphetamine	Trial court upheld
State v. Lewis 1999 Ohio App. LEXIS 5485, 11/19/99	Methamphetamine sale	Defendant wanted to suppress statements of witness to methamphetamine sales	Trial court upheld
State v. Hughbanks 1999 Ohio App. LEXIS 5789, 12/3/99	Death penalty homicide; multiple issues methamphetamine involved	(See discussion below)	Trial court upheld
State v. McNamee 139 Ohio App. 3d875745.n.2.d 1147, 11/9/00	Possession	Appeal warranted search;"ecstasy" obtained	Trial court upheld
State v. Cates 2000 Ohio App. LEXIS 5387, 11/21/00	Methamphetamine sale	Defendant sold methamphetamine near a school; appealed sentence	Trial court upheld
Saterfield v. Saterfield 2001 Ohio App. LEXIS 2592, 6/13/01	Custody	Appellant contested custody to stepmother; biological mother disqualified due to methamphetamine use	Trial court upheld
State v. Gough 2001 Ohio App. LEXIS 3331, 7/23/01	Drug trafficking	Defendant sought suppression of evidence — primarily cocaine, some methamphetamine	Trial court upheld
State v. Callahan 2001 Ohio App. LEXIS 4633, 10/17/01	Manslaughter; weapon under disability; conspiracy to manufacture methamphetamine	Defendant appealed the conviction based on what he felt was insufficient evidence; the materials involved were methamphetamine ingredients	Trial court upheld for all but conspiracy to manufacture
State v. Ridgeway 2001 Ohio App. 6057 LEXIS 6057, 11/21/01	Methamphetamine sale case	Law enforcement had informant	Trial court upheld

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As the table reflects, a significant emphasis involved issues of search and seizure with defendants attempting to obtain reversals or remands based on the illegal gathering of evidence against them. In one of the more innovative of such defenses, the defendant indicated he had been high on methamphetamine at the time of his arrest and therefore had not been competent to agree to the search of the premises that ultimately resulted in the evidence against him. The Court of Appeals was unimpressed and affirmed the judgment against him.

Some of the issues of these cases involve difficult legal concepts. The notion of conspiracy requires that the state prove an agreement existed to achieve a specific illicit goal, that the parties knew of that agreement and the goal, and that at least one of them committed on overt act in the furthering of the agreement (Davis and Vitullo, 2001). Prosecutors have been accused of padding charges by adding conspiracy when evidence constituting proof of these elements was lacking and unlikely to be found. However, juries have not necessarily been able to deal adequately with the legally complex conspiracy arguments. In *State v. Callahan* (2001), the appeals court found in favor of the defendant on the basis that the conspiracy element was not adequately founded. However, the rest of the case stood.*

In *United States of America v. Thomas Conne James* (2001), a defendant alleged that there was differential selection of persons for federal- vs. state-level charges, the impact of which was to create an arbitrary and discriminatory application of the law. Although the defendant was not upheld in his petition, it is true that state sentencing schemes are more flexible and less likely to result in the degree of severity that the federal guidelines have imposed in federal cases. Thus, for example, in Ohio judges are explicitly given some discretion to raise or lower expected sentencing levels for crimes committed. There are a number of factors that are articulated in the law as suggesting greater or lesser seriousness and therefore meriting greater or lesser outcomes. Among the aggravating factors is a "pattern of drug or alcohol abuse that is related to the offense and the offender refuses to

* Conspiracy has been viewed by the government as a difficult charge to prove in part because of the limitations imposed by the *Cruz* ruling (*U.S. v. Cruz*, 12cr7 F3d 791,795, 1997). On January 21, 2003, the Supreme Court reviewed a conspiracy case and reversed *Cruz*. up until January 21, for example, defendants could be found guilty of conspiracy (which is an important component in drug cases for obvious reasons) only if they believed they were in the conspiracy before it was ended by police action. In *United States of America v. Francisco Jiminez Recio and v. Adrian Lopez-Meza*, the Ninth Circuit ruled that *Cruz* pertained; even though the judges expressed repugnance for the *Cruz* ruling (270 F.3d 845, 2001 U.S. App. LEXIS 23404, 2001), they followed it. However, in the ruling on the 21st, the Supreme Court reversed *Cruz* on the point of whether the conspiracy had to be ongoing and not stopped by police for defendants enrolled in actions pursuant to the crime to be charged as co-conspirators (the police had spotted the vehicles, arrested the initiators, and set up a sting to catch the two people the initiators called to pick up the truck).

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acknowledge that the offender has demonstrated that pattern, or the offender refuses treatment for the drug or alcohol abuse" (ORC 2929.12 (d)(4)).

Case law in Ohio, however, has given rise to some interesting and varied precedents. Thus, for example, in a 1984 case, *State v. Burkholder*, evidence obtained in an illegal search was allowed in a probation revocation proceeding. However, in 1996, under *State ex rel, Wright v. Ohio Adult Parole Authority*, the use of illegally obtained evidence was considered inadmissible. Interestingly, drug use may or may not be considered a probation violation depending on the conditions under which it occurred and the conditions that prior existed for the probation. However, the use of illicit drugs usually involves criminal charges, which then become the basis for revocation. In the case of the death penalty, aggravating and mitigating circumstances are articulated, as is usually the case across the country. Drug use is not an aggravating factor but statutory mitigating factors do not include it either. The statute, however, explicitly indicates that the defendant "shall be given great latitude in presence of evidence." Case law, especially *Lockett v. Ohio* (1978), assures that in relevant situations drug use, abuse, and dependency may be presented as part of the mitigating picture.

A review of some other state approaches is consistent with the situation in Ohio. In Hawaii there are specific factors to be considered and the trial court is given significant and explicit discretion. With respect to probation, the court may require drug testing regardless of whether drugs were part of the offense. The court may consider the defendant's past history of use and the possible contribution that drug use might make to recidivism in ordering the testing procedure.

The approach in California is consistent. It does, however, specifically mention heroin, cocaine, and "any analog of these substances" as meriting enhancement of sentence (Article 11353.1 California Health and Safety Code). The code section further specifies that if the offense involves the substances and takes place close to children's facilities and certain other kinds of community settings, that enhancement is desirable. In that regard, the California code is somewhat similar to the federal sentencing guidelines. Interpretations of the California approach have suggested that the court must consider alcohol dependence as mitigatory and should not consider it as an aggravating aspect. On the other hand, the court does not have to consider drug use as having mitigation value where that use did not directly predispose to the commission of the crime.

During the 1990s at the state and federal levels, three strikes laws were passed. California's three strikes law was particularly Draconian in drug-related cases, leading to life terms for minor possession convictions. Under the California statute, crimes usually considered misdemeanors could become felonies leading to long-term incarceration. The "upgrade" of

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misdemeanor to felony provision for sentencing purposes has been found unconstitutional by a circuit court of appeals, but the state appealed and the matter has been set for Supreme Court review (Gearan, 2002).*

Federal Sentencing Scheme

From the perspectives of sentencing in federal court, relatively recent sociolegal history has to be considered. In 1984, the Sentencing Reform Act set up the machinery for federal sentencing guidelines to be drafted and then subsequently amended by the U.S. Sentencing Commission. The interaction between Congress and its own creature (the commission) became an interesting process. There was a Supreme Court challenge to the validity of the Sentencing Commission. However, the functioning of this organ was upheld (*Mistretta v. U.S.*, 1989; Parker and Block, 2001).

The overall purpose of the act and of the subsequent guidelines was stated to be an improvement in "honesty, uniformity, and proportionality" (Ruback and Wroblewski, 2001, p. 744). However, it can also be viewed as part of the trend toward a more conservative and punishment-oriented system of justice. Illustratively, the purposes of sentencing were articulated to be just punishment, deterrence, incapacitation, and rehabilitation, in that order. Even as Congress passed this act and then established the Sentencing Commission, Congress continued, however, to amend the sentencing process with specifics that amounted to a "micro-managing" of the process. The Crime Control Act of 1990 included sentencing guidelines specific to methamphetamine offenses, and the Comprehensive Methamphetamine Control Act of 1996 increased those penalties.

Not surprisingly, the U.S. Sentencing Guidelines as they have developed out of this history fulfill the priority placed on punishment. The guidelines involve a highly complex system of levels with rules for enhancement or reduction (upward or downward adjustment). With respect to methamphetamine, the emphasis is quite clear. Methamphetamine leads to a vulnerability to enhancement of any penalty range that is mandated for given crimes. The guidelines are explicit in this regard, and methamphetamine has been singled out as a drug-among-drugs that can lead to upward adjustments. Special tables exist for amounts that are associated with such adjustments. The guidelines also reflect the current awareness that the production of methamphetamine is dangerous to nonparticipants and the environment generally (see Vogt, 2001). Thus, methamphetamine manufacturing leads to very specific enhanced penalties with quantity, manner of disposition, including

* On March 5, 2003, in Lockyer, *Attorney General of California v. Ardrade*, the Supreme Court upheld the constitution of the California statute (http://www.findlaw.com/us/000/01-1127.html).

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"likelihood of release into the environment of hazardous or toxic substances," duration and extent of manufacturing, and location of the laboratory (enhancements are based on whether the facility is near children or other persons who are relatively defenseless) (Federal Sentencing Commission, Guidelines Manual, 2001).

Thus, methamphetamine, rather than having mitigatory potential, can be an explicit basis for upward departure increasing sentence severity. Consistently, a diminished capacity plea at sentencing under the current guidelines is specifically disallowed if voluntary drug ingestion is involved.

Evaluation of Defendants and Context

Purposes of Evaluation

All forensic evaluation and analysis takes place within a legal context and properly focuses on the questions before the court. As the foregoing section illustrated, there are relevant precedents that constrain both questions and variables, which may be entertained by the court. It is within that context that evaluation takes place.

Mitigation in sentencing involves the notion that some agreed-upon level of punishment for the crime committed can be adjusted in the direction of leniency if factors particular to the person and situation warrant such consideration. Mitigation is a basic part of all legal codes and has been present either in content (by defining offenses according to some set of standard factors to be greater or lesser) or by reference to modifying conditions (the Code of Hammurabi written about 1700 B.C.E. contained such specifics) (Danesh-Khoshdoo, 1991).

More currently, the resurrection of capital punishment after *Furman* (1972) created sets of definitions of mitigatory factors and a body of case law further elaborating what could or should be brought to the attention of the jury or judge. Following *Lockett v. U.S* (1978), inclusion of individually based information resulted in drug related factors being placed in evidence at trial levels and subsequently becoming a focus in appeals.

In any mitigatory evaluation, forensic psychologists need to develop information on factors relevant to the likely outcomes of available sentencing alternatives. To provide the court with valid input, it is necessary to focus on both actuarial and individual case-related data. Risk analyses (see below) provide a valid basis for making predictions in instant cases. Such analyses are only as good as the large-scale studies on which they are based and on the degree to which the individual being evaluated is properly considered as a member of the reference group of those studies.

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While substitution of clinical impressions for properly constructed actuarial predictions has been criticized on scientific grounds (Meehl, 1996; Grove and Meehl, 1996; Ruback and Wroblewski, 2001), even statistically based techniques include measures of dynamic, or potentially changeable, factors. Furthermore, within the limits provided by statistical analyses, more detailed and individualized assessment allows insight into factors of relevance to the treatment process that themselves may have actuarial implications. For example, completion of sexual offender treatment has been shown in some but not all studies to reduce recidivism potential (Hanson and Busière, 1998; McConaghy, 1999).

Risk Analysis

Even with a judge predisposed to consider sentencing from a rehabilitative justice perspective, there is a duty to engage in an assessment of the factors that are part of protecting society vs. the factors that favor a less restrictive type of outcome. In those jurists who are not predisposed to consider rehabilitation as a primary purpose, administration of justice, the importance of victim impact, and the need to send a message of disapproval by way of punishment of offenders will outweigh offender potentials for rehabilitation. However, regardless of the underlying philosophy of justice that a court may hold, that part of the decision making that is based on an assessment of the needs of society for protection may be impacted by an appropriate risk analysis.

Because that is true, most, if not all, pre-sentence investigation reports include outright or implicit risk analyses. However, what can also be said is that pre-sentence investigation reports do not reflect a high level of scientifically informed assessments and basically incorporate what have been statutorily or by regulation determined to be the relevant risk factors. Thus, in Ohio, the following areas are typically found in pre-sentence reports: basic demographics, identifying information, family information, arrest history, gang affiliation, health (physical and mental) status, drug/alcohol use, military service, financial information, employment history, and defendant's perspective on the instant offense.

By contrast, the current level of risk analysis is well past that point when Monahan (1981) was warning against psychologists' involvement on the basis that the insecurity and unreliability of such analyses made that activity unethical. At this point, three generations of scientific work later, certain assertions can be stated with respect to risk analysis:

- There are legitimate actuarially based approaches to risk analysis that do provide valid information about low base rate behavior and that have now been tested for long enough periods that reasonably

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informed decision making can take place on the basis of the data yielded in the individual cases. Further, there are refined statistical methods for dealing with that data (Hall, 2000).

- Actuarial assessment alone, however, has been possibly misapplied in the criminal justice system depending on the level of sophistication of the examiner. Actuarially based instruments include both static and dynamic factors. To the extent that an instrument is based only on static (unchangeable) qualities, the implications are negative for rehabilitation — in effect, a self-fulfilling prophecy that will never change because the items upon which it is based are themselves immutable and the outcome has been fixed (McConaghy, 1999; Mulvey and Lidz, 1985, 1995; Rice et al., 1991; Quinsey et al., 1998).
- However, it is clear that tampering with an actuarial system on the basis of clinical intuition not only offends *Daubert* (1993), but has also been appropriately criticized because it does not show any reasonable promise of scientific adequacy (Grove and Meehl, 1996).
- The current generation of statistically based risk analysis includes instruments (Table 11.2) that involve both static and dynamic aspects, which can be used not only to provide scientifically reasonable predictions, but also to suggest appropriate intervention modes such that risk levels may be reduced, depending on subsequent behavior and outcome of intervention.

A review of the content of the instruments listed in Table 11.2 shows that drug abuse is only sometimes one of the factors used in prediction. It is, of course, considered a dynamic factor because it can be, at least theoretically, altered as a function of treatment or situational input. However, none of the instruments differentiates the use of amphetamine derivatives, including methamphetamine, from other drugs. Some instruments have isolated opiate and heroin use as specific predictors. In Hall's approach (see Chapter 16) an effort has been made to isolate the factors that are specific to this particular drug and their implications for risk analysis. It appears that methamphetamine operates to potentiate violence in persons with a history of violence. A cyclic pattern is typical in chronic methamphetamine addiction and its action as a releaser for violence. General forensic principles with respect to violence prediction should be followed, along with an appreciation for specific mechanisms that can operate in the case of methamphetamine intoxication or a use history for that substance. An assessment of methamphetamine use and its relationship to offenses committed can be a basis for recommending treatment that may reduce violence potentials. However, the research is yet to be done that allows methamphetamine use per se

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Table 11.2 Risk Analysis Instrumentation

Instrument	Purpose/Limitations	Bibliography
Client Management Classification System (CMC)	Developed in Wisconsin, involves semistructured interview, which explores specific "criminogenic" factors; allows a set of treatment specifications that has been associated with reduced risk in 18-month follow-up studies; follow-up research is quite insecure	Eisenberg and Markley (1987); McManuis, Stagg, and McDuffie (1988); Dhaliwal, Porporino, and Ross (1994)
Hare Psychopathy Check List — Revised and Screening Version (PCL-R; PCL:SV)	20 items (PCL-R) or 12 (PSL:SV); static and dynamic factors involve significant experience and training needed to use adequately; substantial research backing as a general predictor of violence recidivism and also for sexual violence	Hare, Harpur, Hakstian, Forth, Hart, and Newman (1990); Hart, Cox, and Hare (1995); see also other publications
Level of Surfaces Inventory — Revised (LSI-R)	54 items, Yes/No format, static and dynamic variables; good support for prediction and monitoring of risk levels	Andrews and Bonta (1998)
Minnesota Sex Offender's Screening Tool — Revised (MnSOST-R)	12 items with associated scores, which reflect positive and negative correlations with recidivism and include both historical and static variables for use only with persons who have been incarcerated and are being considered for release	Epperson, Kaul, and Hesselton (1999)
Offender Group Reconviction Scale (OGRS)	Developed in England and Wales, scale is rapidly being implemented in pre-sentence investigation throughout those parts of the U.K.; consists of six items; has been shown to predict reconviction within 2 years in 83% of cases	Copas and Marshall (1998); Cooke and Michie (1998)
Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR)	Four items with liability and validity data; developed in Canada; static factors	Hanson (1997, 1998)
Risk of Reconviction Scale (ROR)	Developed in England and Wales to predict suitability for parole; six items with weighted positive and negative scores reflecting positive and negative correlations of the items, and differentiated for general re-offending and serious re-offending (see also OGRS)	Copas and Marshall (1998)

(continued)

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Table 11.2 Risk Analysis Instrumentation (Continued)

Instrument	Purpose/Limitations	Bibliography
Salient Factor Scale (SFS)	Developed by U.S. Parole Commission; six items; static and dynamic factors, including specified heroin/opiate dependence	Gottfredson, Wilkins, and Hoffman (1978); Hoffman (1994)
Sexual Offender Risk Appraisal Guide (SORAG)	Developed out of the MacArthur studies and work on the VRAG; 14 variables; not significantly better than the VRAG for prediction of violent recidivism in the sexual offender population	Quinsey, Harris, Rice and Cormier (1998)
Sexual Violence Risk–20 (SVR-20)	20 factors with static and dynamic aspects; evaluator determines risk level on the basis of experience with the population; factors are empirically valid, but instrument has not been statistically validated	Boer, Wilson, Gauthier, and Hart (1997)
Static 99	Refinement of the RRASOR; 10 items, all static, coded present or absent	Hanson and Thornton (2000)
Violence Risk Appraisal Guide (VRAG)	12 items; includes the PCLR score, thus reflecting all of those variables and implicitly counting certain items twice; empirically based, with ongoing research	Quinsey, Harris, Rice, and Cormier (1998)

to be treated as a statistically based predictor in the absence of other established indicators.

A specific pattern of lethal aggression involves homicide–suicide, the co-occurrence of aggression directed toward the self and others. Trained police officers know that dealing with persons who are actively threatening suicide can be dangerous because of the potential to redirect the aggression toward the officer. Specific studies of behavior involving acts of aggression against self and others have not included methamphetamine or other stimulants but have identified that opiates and alcohol may be predictors. Given the dynamics of methamphetamine and its potential for mood destabilization as well as reduced executive function, further research into all aspects of aggression directed both inward and outward needs to specify in more detail substance abuse patterns, including especially methamphetamine (Hillbrand, 2001).

Malingering

At all phases of the forensic evaluation, malingering is a significant issue because motivation to present in a fully disclosing and honest fashion is generally less likely than would be the case in other contexts. As indicated by Hall and Pritchard (1996), evaluation of malingering in methamphetamine

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cases is complicated because methamphetamine genuinely impacts cognitive function causing both short-term and more subtle or chronic long-term defects. Furthermore, acute and chronic impacts of methamphetamine can produce psychotic-like mentation. Finally, in individuals who are predisposed or have preexisting mental illness, the use of methamphetamine may worsen the symptom picture.

Legal context obviously has an impact on impression management approaches. It is not uncommon for methamphetamine users to deny or minimize the part played by the drug in an instant case, since they usually know or are told by defense counsel that voluntary ingestion of substances is not exculpatory (Hall, Chapter 14). In the case of a postconviction evaluation, there is also likely to be significant interest in being seen in a sympathetic light. Therefore, the motivation to consciously emphasize psychopathology, and to attribute it to mental illness, is often present. From an affective standpoint, there may be depressive reactivity by virtue of the situational factors being faced (prospects of extended time in prison), and there may also be an underlying biochemical basis for depressive reactivity due to the extended withdrawal.

For the most part, psychological instrumentation is not at the level necessary to definitively evaluate the percentages to which given symptoms may reflect malingering. It is also very difficult to determine, in the case of an actual psychotic-like presentation, whether the cognitive distortions are methamphetamine residua or symptoms of an underlying, preexisting, and ongoing mental illness of a schizophrenic or similar type. Differentiating "real" vs. "manufactured" mental problems involving either cognitive or emotional illness can be problematic and certainly requires data beyond that of the presentation and products of the defendant.

Evaluation of malingering has been further complicated by case decisions that have defined conscious attempts at distortion in the course of such evaluations to be indicators for upward adjustment to sentencing guidelines (see, for example, *United States v. Pineda*, 1992). A double-edged scientific and legal dilemma presents. The responsible forensic practitioner is under an ethical obligation to acknowledge and investigate malingering potentials. However, the identification of malingering not only assists the psychologist and court in assigning weight to psychological findings, but also potentially affects the defendant harmfully. Malingering as a condition is hard to diagnose or "prove." Therefore, the practitioner is under an obligation to come to this conclusion only by careful development of supportive data (Melton et al., 1997; Rogers, 1997).

Some approaches that can be helpful in dealing with this dilemma are the following:

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- Repetition of cognitive assessment for comparison to that done closer to the time of the act, perhaps as a function of a defense expert's evaluation or a court-ordered evaluation due to questions of reduced or exculpatory status.
- Review of historical data using records produced prior to the instant offense; prior records of mental illness.
- Interviews of family, employers, or school personnel. School records, especially from pupil personnel sources or from schools where actual narrative reports of behavior are maintained, may be of assistance.
- Defendant retrospective of the crime. A close to verbatim account of the criminal activity can be evaluated against independent evidence in the record and other interviews and interrogation to determine whether significant minimization or distortions can be identified. Patterns of distortion can be evaluated for known impacts of methamphetamine use on time perception and memory function.

Procedures

Interview

Interviewing allows a behavior sample that itself can be interpreted. It also provides information that a defendant is willing or able to share. Methamphetamine is known to impact cognitive functioning in a variety of ways but is not determinative of either content or type of distortions that may occur in instant cases. As is always the case in interviewing individuals accused or found guilty of crimes, issues of malingering arise. However, in chronic methamphetamine users, organically based misrepresentation of facts also needs to be considered.

The interview needs to gather the usual materials in a clinical assessment (personal history, family history, health status and history, educational and vocational background, legal history, mental status functioning, and obviously a history of drug/alcohol abuse including onset and patterns of use). The specifics thus obtained can be evaluated against available third-party and record information, providing insight into the degree of consistency and possibly identifying patterns of dissimulation (self-aggrandizement, omissions, projection of responsibility). The use of some type of underlying structure at least for coverage of topics can be recommended.

A retrospective on the instant crime may or may not be obtained. Even after a finding of guilt, some defendants maintain innocence and look to the appeals process for vindication. Defendants may be instructed not to discuss the crime by counsel. On the other hand, in some cases, counsel will urge the clients to review in entirety and with honesty their memory of events as they transpired. This material may be of substantial value in the sentencing

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process (it may illustrate remorse and insight, for example) or it may significantly affect risk analyses (for example, the PCL-R). It allows specialized inquiries into unusual aspects including analysis of the relationship of the defendant to weapons — Meloy's (1992) Weapons Assessment can be used where appropriate — or to distorted thinking, especially in sex crimes. It may provide examples of the impact of the drug on cognitive functioning, referencing a sense of rapidly occurring events that actually took far longer (time distortion) and problems around detail recovery (encoding and retrieval memory problems). See Chapter 14 for a fuller discussion of factors of cognitive distortion vs. malingering.

In obtaining a retrospective from the defendant, the use of an inverted triangle model of interviewing, with an emphasis on the devices of the cognitive interview (Fisher and Geiselman, 1992; Milne and Bull, 1999), is recommended. Initial inquiry is open ended: "Tell me what happened. Begin at the beginning and give me as much detail as you can remember." After the defendant provides an account (with nonspecific encouragement: "What happened next?" "Just tell me what you remember"), one can focus on specific aspects and ask for particular details of what was experienced ("Describe for me what it looked like when …" "I wonder exactly what you could see when…" "I wonder if you could hear anything going on when …"). Ask about how long sequences took where that information is not spontaneously provided.

This type of extended inquiry into the criminal behavior is not always either possible or desirable. However, when it is undertaken, using auditory taping can be of significant help in obtaining the kind of very specific response information that lends itself to forensic analysis. In some jails, it is possible to arrange in advance permission to do such recording; many facilities will not allow it without such permission and it would be hazardous to attempt it without checking on local rules. Sometimes a court order is necessary for a recorded interview. Learning a highly adequate form of shorthand is a boon to any forensic evaluation.

Data obtained in the course of the interview may be applicable to an understanding of the offense and motivational state, which are clearly relevant to the sentencing process. It allows insight into characterologic features, which are often a focus at this stage of criminal justice. Treatment or other rehabilitation efforts may be enhanced by the findings.

Psychometrics

A review of current literature produced little in the way of specific patterns associated with methamphetamine abuse. Most research has been done on the impact of alcohol, cocaine, or polysubstance abuse. Research on stimulants as a class is also available for extrapolation.

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In the area of neuropsychological functioning, there has been some attention paid to impacts on memory, attention, psychomotor measures, and processing variables. Common instruments used for investigations have included the Wechsler Adult Intelligence Scales (currently, the WAIS-III), the Wechsler Memory Scale (R or III), Trailmaking Test, Wisconsin Card Sort Test, and other instruments that reflect variables associated with cognitive deficits.

One recent study looked at memory deficits in MDMA abusers with initial testing and follow-up 1 year later. Results documented other sources of observation, which suggest that ongoing methamphetamine use leads to progressively increasing neurocognitive deficits (Zakzanis and Young, 2001). McKetin (2000) documented poor performance on all indices of the WMS-R for amphetamine dependent persons vs. impairment specific to visual memory tasks for heavy users but not those meeting dependency requirements. Other analyses indicated patterns on attentional tasks by those classified as dependent that were indistinguishable from psychotic and affective conditions. This study, however, may be only suggestive for methamphetamine abusers.

Attention deficit hyperactivity disorder (ADHD) has been a focus of some investigations. Hypotheses that ADHD may be related to inability to profit from standard approaches in substance abuse treatment have been evaluated and only partially supported. Associations between ADHD and substance choice have been considered, especially referencing psychostimulants. However, such studies highlight the differential diagnostic dilemma: underlying and preexisting organic bases for neuropsychological divergence from normal exist along with those deficits that are produced by substance abuse. Similarly, studies of substance abuse and schizophrenia have shown overlaps in patterning on neuropsychological testing (Snyder, 1998; Badgett, 1999). As methamphetamine is known to have impacts on memory, perception, and executive control functioning, as well as presenting substantial issues for identifying and ruling out malingering (particularly of mental illness in order to be seen as less culpable), obtaining standardized data from the defendant, in addition to his or her reports, is an important component to the assessment process. However, it may or may not be possible to do extended neuropsychological screening at the pre-sentence level in many cases. Where interview and other data strongly suggest an organic component, the expense in time and money can be justified. In some cases, neurological assessment (CT scan, MRI) may be possible, but would be rarely approved in the vast majority of such cases.

Instrumentation that can be utilized at a screening level includes WAIS III; Wechsler Memory Scale R or III (argument can be made for use of the older instrument — the third edition contains some statistical anomalies and is so specialized that very occasional use is likely to lead to administration

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errors); Trailmaking; Rey Figure; Bender Gestalt (although much maligned, as a screening assessment of both gross perceptual motor functions and as an informal means of assessment of task management, it can be helpful — some patterns consistent with psychotic function have been noted in the literature and their presence might bolster ruling out malingered mental illness, presuming other very consistent data as well). All these instruments would have some potential to map strengths and weaknesses of cognitive function that have relevance for capacity to benefit from treatment or the need for special supports in that process.

Personality assessment instruments have also been studied with regard to substance abuse, especially since differentiation of non-substance-related conditions from those produced by use becomes an important issue in recommending treatment interventions. The MMPI contains a number of substance abuse scales (the MacAndrews, the Addiction Potential Scale, and the Addiction Admission Scale can be referenced). Additionally, clinicians know that the Harris and Lingoes subscale Bizarre Sensory Experiences (Sc6) and the Bizarre Mentation Subscales (BIZ1 and BIZ2) can register with substance abusers, especially those who have experienced hallucinatory phenomena.

The strength of the instrument, particularly for forensic purposes, lies in its statistical base and the ongoing production of substantial scientific literature. In regard to issues of malingering, the MMPI tests have built-in validity indicators as well as studies of patterns associated with different impression management styles. In cases of individuals without the capacity to read at approximately a 6th to 8th grade level, it can be administered orally or by tape, but that procedure can be difficult to manage in many criminal justice settings, both for reasons of time and regulations. In general, however, most defendants are capable of taking the test — and most forensic practitioners would have to justify not using it in preference to some other instrumentation, particularly more subjectively based approaches.

The Millon Clinical Multiaxial Inventory (MCMI-III) is a newer but also well-established empirically self-report questionnaire. This test may be of some assistance in identifying specific Axis II configurations and can be helpful as part of the database on which differentiations between likely malingering vs. honest responding have occurred. It is not a good instrument to use to replace the MMPI for Axis I conditions and it overdiagnoses personality disorders such that it should be used where there is reason to believe the individual reasonably has an Axis II condition.

On the MCMI, there have been studies specific to cocaine and more generally to substance abuse that identify patterns of importance, including differentiation of antisocial personality disorder from other personality patterns within the population of substance abusers, the identification of patterns relevant to treatment issues, and the characteristic malingering

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response modes found in different diagnostic groups (Flynn and MacMahon, 1997; Flynn et al. 1997; Weiss, 1998; Messina, 2000; Messina et al., 2001).

The Personality Assessment Inventory is a relative newcomer. It has a much less substantial scientific base than the MMPI tests, but the literature increasingly cites its usefulness. It requires less time to administer, has a lower reading level, and has a built-in method for looking more continuously than dichotomously at traits. (All tests that are completed by the defendant must be actively proctored by the forensic clinician or a qualified agent who can assure that the test was indeed the product of the defendant's work.)

Projective techniques do have a place in forensic work (some forensic practitioners have subscribed to the contrary). However, their strength lies in the insight they provide into intrapersonal aspects of function. The Exner Rorschach has a substantial base of use in the court system and has been cited in numerous cases as meeting scientific requirements over a period of many years. Under certain specialized circumstances, as with death penalty mitigation, extended ways of dealing with content have some relevance for understanding crime and criminal. A forensic psychologist needs to prepare in advance for possible cross-examination about the reliability and validity of this (as of any) instrumentation used. One of the authors (McPherson) has testified in court about the Rorschach using a step-by-step but brief exposition: the test is made up of inkblots which can be seen as many things; the individual produces responses with an inquiry into why he or she said what was said; the responses including all the reasons used are categorized and a count made of categories and numbers of times used; these numbers are then put into relationships with one another — often ratios — which allow patterns to emerge that are associated in the scientific literature with different personal characteristics. McPherson has never had to go any farther than that in explication.

Other projective techniques have less frequent application to forensic assessment at the pre-sentence level, although any data regarding personality structure and functioning may be of interest and relevance to treatment that may be mandated. Thus, responses to sentence completion techniques or even versions of the Thematic Apperception Test may be included as supportive or illustrative, but not determinative, of the examinee's characteristics.

Context

It is at the level of developing information regarding contextual factors that the most reliance on third-party information (TPI) is likely to occur. As with data produced by way of traditional individual assessment procedures, there is concern with issues of reliability and validity from a scientific standpoint further underscored by *Daubert* (1993) decisions and other rule of evidence

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precedents. Evaluation of TPI should consider the source of the product and should not presume accuracy due to status of the informant (see discussion in Melton et al., 1997). An attitude of objectivity and skepticism serves well in dealing with these kinds of data.

Categories of TPI

Different data sources with associated concerns follow:

- School Records. Information is not likely to be contaminated by immediate case-related variables. Reliability for academic and intellectual function is high; bias can impact behavioral items, especially if the individual was disliked or identified as a "bad apple."
- Juvenile Records. Information relative to offending is likely to be highly accurate; if anything, the degree of antisocial behavior will be understated since the data cover only those acts for which the defendant was apprehended.
- Adult Criminal Records. Same as above. However, it can be noted that minority and impoverished status predispose to criminal behavior and to winding up in the system to a greater degree than is true for those with higher status and wherewithal in the society. Therefore, the meaning of a significant "rap" sheet might be more indicative of psychopathic character referencing a middle- or upper-middle-class defendant, whereas it may reflect general antisocial behavior in the case of an inner-city gang member.
- Prison Records. Generally good sources for capacity to conform to highly structured environments, these records are a reasonable basis for predicting adjustment to prison in the future. However, disciplinary incidents may or may not reflect potential and actual misbehavior of a defendant. There is corruption by virtue of the power imbalance (Zimbardo et al., 1972), racism, and other factors that can impact a prison record.
- Treatment Records. Records predating the offense may be viewed with confidence regarding mental status, diagnosis, and response to treatment, as well as possibly contain information important to background, family, and other history. Records from a treating professional that postdate the offense may be subject to unconscious bias of the treating therapist who is invested in his or her patient, as well as reflect what the defendant may want to promote.
- Reports from Family Sources. Both positive and negative bias based on highly individual factors of relationship and history has to be considered.
- Police Reports. Generally viewed as highly reliable and valid by the court system, some skepticism is nonetheless warranted, particularly

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where racial factors may be involved, or where the police have felt themselves victimized by the defendant or associates. Police brutality is less common than many defendants may believe, but it is not unknown and when it occurs there is motivation to cover it up by attributions of violence to the defendant in the course of confrontations.

- Victim Statements. Again, victim statements have high regard from the court system, but cannot be accepted without some scrutiny. Particularly in cases of sexual offenses, context and motivation of the reporter have to be considered. That said, it must be noted that a false report of sexual abuse is a low base rate phenomenon.
- Crime Scene Data. Information from the investigation of the crime scene can be of particular importance in methamphetamine (or any) cases involving violence. The interest is often in whether the violence was spontaneous and not under good executive control. Crime scene pictures and descriptions can provide important input to that issue.
- Medical Records and Medical Examiner Reports. The information is usually of good quality. However, there have been instances of incompetent or corrupt medical examiners. Recently, in one jurisdiction in Ohio, it was identified that a given period of time involved an essentially automatic classification of questionable infant deaths as accidental rather than raising the possibility of homicide, leading to extended but belated investigations (Sangiacomo, 2002).
- Interrogation Reports and Tapes. Any taped interview or statement has a certain amount of face and real validity. When the entire interrogation is documented, issues of suggestion and coercion can be evaluated, but in the U.S. that is a rare occurrence.

Reporting to the Court

In general, forensic reports follow a format of identifying information, procedure, and results. In many teaching settings, there is a preference expressed for what is known as fully integrated reports where all data are combined into a description of the individual and referenced periodically throughout the body of the report, after which there are diagnostic and conclusion or treatment recommendation sections. The forensic report, however, must withstand the scrutiny of the legal system and there is an obligation to make the data reasonably accessible to the process of examination and cross-examination. Toward that end, the following format is recommended:

- Identifying information. It is important to include birth date and any other specific identifiers that may be an ongoing basis for assuring that the report references the defendant. It is also important to include

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a description of the offense. All reports need to be identified as to the purpose of the evaluation.

- Procedure. Sources of information relied upon should be listed. It is particularly true in performing second opinions or assessments for defense counsel that some information available through the court system may not be made accessible to the psychologist. By listing those materials that are used, unnecessary challenges are avoided and necessary ones can be made.
- Detailing results. This section contains results of interviews, including mental status examinations, history as obtained from the defendant, retrospectives, which may be reproduced verbatim at times, and other defendant-generated information. A separate section should be provided that details results from third-party information and provides specific sources for specific items and sections for cognitive and personality assessment, which detail the relevant results from test data. Scores should be included in these reports. It would be rare to include personality profiles with the report although they may be made available upon appropriate demand; however, computer-generated interpretations for personality assessment instruments should never be a part of the report to the court.
- Diagnosis. The DSM-IV system should be used but modifiers that are significant in identifying defendant status can be inserted into the diagnostic presentation. It is desirable to include all five axes but it is necessary to include Axes I through III.
- Summary and recommendations. It is in this section that the foregoing data are integrated into a set of logically connected and scientifically founded conclusions and recommendations. A risk analysis may be part of this section, in which case the particular instrumentation needs to be referenced with the specific outcomes. In methamphetamine-related cases, coverage for substance abuse in the course of the defendant's narrative and any relevant commentary from third-party sources and in the diagnostic section need to appear. Treatment recommendations should be based on the data and should specify needs and parameters that will enhance the potential for treatment success. In most methamphetamine cases, particularly where use has been in any way extended, concern should be raised for neuropsychological functioning and a recommendation made for assessment as appropriate along with inclusion of compensatory work and education in the treatment plan. As is always the case, the forensic report addresses the particular legal questions that are present. Therefore, the instrumentation chosen, as well as the conclusions rendered, often needs to speak to issues of recidivism and the factors that may serve to reduce that potential. Another area that needs to be covered in the

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final section and related where appropriate to recommendations is the role that methamphetamine and other substance abuse played in the instant offense. This connection is particularly relevant for recommendations that aim at reducing recidivism potentials.

Final caveat: A good psychological report describes an individual and is written in a way that compels attention. However, it is also well known that the part of the report that is most likely to be read, especially by persons such as probation officers writing pre-sentence investigation reports (PSIs) and judges, who have asked for the information, is the last section. That section must embody all characteristics of good legal writing: clarity, logical structure, and linear reasoning.

Other detailed helpful information for approaching court-related evaluations can be found in Melton et al. (1997).

Pre-Sentence Investigation Reports

Pre-sentence investigation (PSI) reports that are submitted by the probation department are of substantial importance to the sentencing process. However, there is significant variation in content and degree of independent judgment actually exercised by the writers. In some settings, there are guidelines for the collection of data with an expected, almost rote production of the report. In other places and sometimes within settings, there are expectations for individual initiative based on experience and training. Instructions to probation staff can exert a measurable impact on both the content and, ultimately, the outcome of the sentencing process. (In one case in our experience, a political agenda operated to support punishment; the PSI was replete with all the usual markers for probationary eligibility — first offense, restitution made, remorse evident, punishment from other sources already occurred, offender employed and had family responsibilities, support system existed, no personal risky habits — but the usually present recommendation section was not completed, increasing the ability of the prosecutor to obtain a higher severity than was objectively warranted.)

Psychological reports may or may not be referenced in a PSI. Sometimes, such evaluations may be submitted independently by defense counsel or requested by the court. Psychological reports tend to be most valued when they provide a rationale for what the court has determined will take place. To some degree, this is due to the view of clinicians as having an overly liberal bias and being more "soft-hearted" than defendants warrant (Melton et al., 1997).

As has already been documented in the legal literature, a factor of substantial importance in the sentencing process is drug use, particularly where that use may have precipitated aggression. The issue of drugs as

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precipitating *uncharacteristic* aggressive behavior may be raised as mitigating, but it is as likely as not that the voluntary use of methamphetamine in particular will have an opposite impact on sentencing outcomes. As was seen in *Lopez v. Davis* (2001), the inclination to classify drug use and trafficking as more aggravating than mitigatory extends to eligibility for early release consideration.

One of the authors (McPherson) was present at a sentencing hearing in which the presiding judge accepted a seriously mentally ill defendant's guilty plea to bank robbery. The judge refused to hear any mitigatory testimony on behalf of the defendant and lectured him on his immorality and unworthiness for mental health treatment or other consideration by society. The foundation for the judge's approach was that the defendant had a history of drug involvement and therefore his mental illness, if indeed he had such, was a function of his own doing (the defendant had a clear and independently documented family history of mental illness and exhibited classical symptoms of schizophrenia). A harsh sentence was levied; attempts then had to be initiated in the prison system to obtain the medication to which the defendant had been responding but which was not being prescribed due to the judge's "diagnosis."

Clearly, even with careful use of data and documentation of sources, psychological reports may have an impact different from that intended (or no impact at all). Clinicians who identify substance use as a mitigatory circumstance need to understand that from a legal perspective it is a double-edged sword. They are also providing evidence of a factor that may be seen as cautionary for rehabilitation and subsequent safe release (Melton et al., 1997).

Although a treatment approach for addiction is more likely than a retribution or punishment model to lower recidivism when successfully completed (see below for further notes on treatment characteristics and see also Chapter 17), that fact is little appreciated by many jurists. In a pre-sentence evaluation, the forensic clinician must consider two major aspects:

- To what degree was the crime a function of a correctable and diagnosable condition (for example, methamphetamine dependence), on the basis of which recommendations may be made for treatment? Such recommendations reflect a rehabilitative approach to criminal justice.
- On the other hand, to what extent has an individual operated aggressively while under the influence of methamphetamine? In such cases, a known increased risk of recidivism is present, which may argue for a longer sentence and more caution regarding any conditional release (Miller and Potter-Efron, 1989; Melton et al., 1997).

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The actual relationship between crime and drugs is complex and may involve a primary criminal motivation (i.e., money) or may reflect correlations with other factors (e.g., contaminated drugs, characterologic features of the offender, or psychosocial/environmental aspects). Some studies have demonstrated that intake of drugs predisposes individuals to reduce their sense of personal responsibility, to behave impulsively, and then to blame the outcome on the intoxicated state (Lang et al., 1976; Fagan, 1990; Brochu, 1992). Brochu's (1992) review of the literature for the period 1972 to 1992 did not support the conclusion, however, that amphetamine or other stimulants per se were major defining factors to account for violent crime. Rather, the consensus supported the relative importance of contextual factors and multicausal analysis. Similarly, the findings by these writers regarding cases evaluated at a court clinic and cases seen at a hospital (see below for details) supported a complex view of the causes and onset of aggressive behaviors. Thus, both criminological studies and clinical evidence support individual assessment in developing risk estimates (Hart, 2001).

Survey of Methamphetamine Cases Evaluated in a Court Clinic

Although assessment and treatment options in the county from which the below cases were reviewed are better than many, they are generally available only to defendants for whom a mandatory prison sentence is not involved. The general inclination of judges at this court is to refer whenever they perceive questions about treatment-related issues. It is the impression of the court psychologist that defendants referred for a pre-sentence psychological evaluation often are seen as having greater potential for treatment than incarceration.

The focus for psychological evaluations as the psychologist reported it is to develop information relevant to the mitigation and sentencing issues and to the risk of violation of probation where a treatment package is recommended. In his opinion, further evaluation of the substance-related and other treatment aspects of referred defendants should be a component of any ongoing treatment facility.

The major sources of referral are the judges on their own initiatives, motions by defense counsel, or the request of the probation department where initial psychosocial history leads to a question of psychological status. The majority of referred persons with substance-related issues attend outpatient therapy for their drug-related problems, although some undergo inpatient programs prior to outpatient phases. Two major treatment options are typically used. In one setting, the treatment approach is based on the presence

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of an existing criminal lifestyle associated with the drug use. In the other, the defendant does not appear to have established a criminal lifestyle, but has had some drug treatment with relapse. Most defendants attend the jail treatment program prior to release.

The general procedure involves a screening assessment with an interview, Carlson Psychological Survey, MMPI-2, Substance Abuse Subtle Screening Inventory III (SASSI-III), a Pre-sentence Questionnaire (filled out by the defendant), review of police and prosecutor file reports, and review of prior criminal history record. In some cases, the assessment is done by a substance abuse counselor, with review of the MMPI-2 by a psychologist but reportage only of substance-relevant data from that instrument.

The following cases represent a sample of recent evaluations in methamphetamine-related instances. In the associated commentary, an emphasis on the treatment needs and likely outcomes given treatment opportunities is presented.

Case "AB"

AB was a 44-year-old white male arrested with a codefendant for possession of methamphetamine and involvement in manufacture.

Evaluation found him to show no signs of disturbance on inquiry into mental status, no prior mental health treatment, and a prior criminal history for property crimes. Inquiry of the defendant into substance-related issues resulted in information that he was abusing alcohol twice per week, had had five DUIs (the last occurring 15 years prior), and that he showed tolerance. He admitted to using cocaine during his 30s three to five times in total, and to initial use of amphetamines in high school. This client, in spite of the conditions under which he was arrested, maintained denial for any kind of methamphetamine use.

MMPI-II was defensive but unremarkable for any clinical elevations. Substance-related scales showed a seriously elevated MacAndrews, but no significant findings on the Addiction Potential or Admission Scales. The CPS indicated a profile consistent with a background of family stability but the presence of personal emotional instability, poor judgment, and hostile behavior. Resulting diagnosis was Alcohol Abuse, R/O dependence, and amphetamine abuse referencing the methamphetamine and the denial.

Comment. This defendant is atypical in many respects of persons seen in the court clinic for drug-related problems. His use as detailed, as well as his age and the lack of an ongoing set of criminal acts, referencing the criminal history, makes conclusions and recommendations tentative. The indicators of ongoing extensive methamphetamine use were not evident in the information available, but the overall impact of the history as obtained is consistent with an ongoing and untreated addictions-based lifestyle. The

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recommendations for the jail treatment program and abstinence are well founded. The likelihood that there will be a recovery status in this case is, however, very low since there has been and probably will be no real focus on the addictions component.

Case "CD"

CD was a 23-year-old white male. He was charged with a felony two possession of drugs, a felony two aggravated possession of drugs, and felony five possession of cocaine.

When initially seen at the jail, he had crying spells and showed significant depressive symptoms but denied suicidality. He was seen again after 3 weeks and his mood state was improved. His substance history included initial use of alcohol at age 12 with tolerance occurring early on. He began drinking beer frequently in junior high school. He reported blackouts, and he indicated that his alcohol use negatively affected his relationships and his work life. At ages 16 and 17, he began the use of marijuana, a quarter ounce every day or eight or nine joints. He began using cocaine laced with opium and hashish. He snorted heroin six times in total. He began crystal methamphetamine at age 18 and used it every day for about 2 years; however, he indicated he had only used it "two or three times" since age 20. He stated he had used LSD about 50 times and was using barbiturates from age 20 to the present on a daily basis. His preferred drug was Valium or Klonopin with alcohol. He also indicated the use of ecstasy once or twice. His criminal record included carrying a concealed weapon and trafficking in cocaine.

Test results indicated significant impacts on his personality and functioning. The MMPI-II was taken in a valid fashion, and he disclosed significant problems. Clinical scales were elevated, especially Scales 2, 4, 6, 7, and 0, which would be consistent with an ongoing depressive picture, withdrawal from positive social contacts, the presence of anxiety, and some underlying characterologic features. The MacAndrews was in the critical range, but the Addiction Potential and Addiction Admission Scales were not highly elevated. The MacAndrews, of course, is the subtle indicator. The SASSI was consistent with substance abuse and/or dependency. The CPS was not remarkable for any specific profile. The diagnosis on the basis of all of the information collected included Axis I: Adjustment Disorder with Depressed Mood, R/O Depressive Disorder, NOS; polysubstance dependence with physiologic dependence and polysubstance abuse; Axis II: Personality Disorder, NOS. Recommendation was for inpatient treatment followed by appropriate outpatient follow-up.

Comment. On the basis of the substance abuse history alone, the clear presence of dependency and primary addiction is indicated. Serious alcohol dependency was already in evidence prior to the maturation of this

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defendant's brain; it can be reasonably concluded that by the time he reached adulthood, he had significant underlying biological mechanisms involving receptor sites that would support and reinforce all types of substance abuse. The degree of ongoing use that has been characteristic of half of his life would call for a more complete neurological assessment and an extended program should there be any hope for success in rehabilitation.

Case "EF"

EF was a 27-year-old white male arrested for a felony one kidnapping and felony four aggravated burglary.

On the mental status evaluation, there were no signs of any mental illness. The defendant was currently prescribed an SSRI antidepressant. Background history was instructive. He was born and raised in a rural setting, the youngest of five children. He indicated no abuse history. His biological parents had significant marital problems and instability. He reported no problems in school, indicated he had never been diagnosed with ADHD. He did not graduate but did obtain his GED. He indicated he was married, but there were problems including a domestic violence conviction in a different state. He also indicated that he had been identified with minor self-mutilation practices at the age of 14. His domestic violence occurred when on drugs.

Substance abuse-related information included that he began the use of alcohol at the age of 6. He stopped use of that substance at 18 but had restarted 3 years ago at the age of 24. At that point he began consuming half a gallon of whisky every 3 days, and he reported tolerance. He was using LSD regularly, marijuana from the age of 13 to 22, cocaine daily from the ages of 16 to 18 with last use at age 22. His crystal methamphetamine use began at age 18 and continued daily until age 22.

His criminal record included domestic violence, rape of his spouse, four DUIs, theft of a firearm, receiving stolen property, possession of methamphetamine, possession of a controlled substance, possession of drug paraphernalia, possession of narcotics, and possession of a stolen vehicle. The current crime involved a female victim and the sudden eruption of violence on his part. He was resistant at arrest and had to be forcibly controlled. His verbal behavior was replete with profanities. He was amnesic for the events at the time of the crime; he did recall drinking and getting into a verbal fight with his wife just before the incident.

Comment. The above scenario is consistent with observed patterns for persons with heavy methamphetamine use history. The potential to return to extremely violent behavior exists over an extended period of time. The accuracy of his statement that he had not used methamphetamine since age 22 is questionable. If true, his behavior would be consistent with the action of a releaser substance (alcohol is a disinhibiter); predisposition due to

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methamphetamine impacts rises with the extent and recency of use of that substance.

Test results and other findings from the assessment process included a valid MMPI-II with some minor elevation on Scales 4 and 6, a highly elevated MacAndrews, as well as subclinical elevation on the Addiction Potential Scale and high elevation on Addiction Admission Scale. The PCLR was at 23, which is moderate for psychopathic character traits but the loading was on Factor Two, the primary predictor of violent criminal behavior.

Resulting diagnosis was Axis I — Major Depressive Disorder in remission and polysubstance abuse and Axis II — Antisocial Personality Disorder with histrionic and psychopathic features. History included treatment for his major depression. The recommendations were for an inpatient treatment program and subsequent halfway house and ongoing aftercare, as well as for anger management.

Comment. This case clearly illustrates the individual who is biologically and psychosocially scripted for an addiction lifestyle and an ongoing lifelong vulnerability to substance abuse and dependency. Furthermore, his risk for violent behavior is substantial, particularly under any conditions where he has engaged in the use of substances that reduce executive control. Although he denied serious dysfunctional aspects of his family life, the early onset of substance abuse and the instability of the parental union, along with the noted self-mutilation habits at age 14, would all suggest that there may be some borderline features to his personality integration with specific liabilities when it comes to relationships with women. Therefore, recommendations should have included further assessment of neuropsychological functioning and a specific emphasis on therapy focused on his relational capacity as part of the long-range treatment plans, but presuming an extended period of control over substance use.

Case "GH"

GH was a 20-year-old white female arrested for illegal assembly or possession of chemicals for the manufacture of drugs, a felony three.

Although her current mental status was unremarkable, depression by history was noted with three hospitalizations and an episode of suicidality occurring 1 year prior. At the time of evaluation, she was prescribed an SSRI antidepressant. She had engaged in wrist cutting. Her substance use included occasional use of alcohol with intoxication occurring only once or twice. She denied any tolerance or other problems. She used marijuana in high school "all the time." Until 2 years ago, she was using an eighth to a quarter of an ounce a week. The current crime referenced her involvement in a methamphetamine lab. She indicated she had used cocaine only twice, and that she

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had been using crystal methamphetamine for 3 weeks to "feel opposite" from her ongoing use of marijuana.

Test results did not show significant psychopathology. The SASSI-III referenced dependency, detachment from feelings, poor insight into feelings, and other attributes often seen in drug users. Her MMPI-II was quite defensive. The resulting protocol was within normal limits, with low points on 7 and 0, referencing a need to present as gregarious and socially adept, and to deny any feelings of discomfort. Neither the MacAndrews nor the Addiction Potential or Admission Scales were at critical levels.

The diagnosis included Depressive Disorder, NOS, referencing especially the clear history in the treatment records, and cannabis dependence and amphetamine abuse. In regard to her methamphetamine use, she maintained that she had only consumed the substance three times, and that she was essentially unaware of the methamphetamine lab in her house (a friend had set up the lab and paid her in marijuana for use of the space). Recommendations of the assessment included the jail treatment program and then postjail abstinence and ongoing substance abuse treatment.

Comment. In all likelihood, she is, as the diagnosis indicated, dependent on marijuana but an occasional user of other substances. A strong educational program about the specific substances and their impacts would need to be part of her substance abuse treatment. However, development of the dual diagnosis component (referencing her underlying depression, for which some of her substance abuse would be self-medicating), as well as detailing her addiction psychology, would be the only way to secure a potential for her to avoid future involvement, both criminally and in relationship to substance abuse. She will be particularly prone to methamphetamine abuse as it would relieve some of the underlying depressive symptomology, which is not addressed adequately by her use of marijuana and may in some cases be enhanced at times. The pattern of denial and minimization is already in place and would need to be a focus of her treatment.

Case "IJ"

IJ was a 21-year-old white male arrested for trafficking in drugs that are not controlled substances, a felony five.

This assessment was completed by a chemical dependency counselor with consultation on the MMPI and diagnosis by a licensed psychologist. The procedure was much more attenuated, including the Pre-sentence Questionnaire, MMPI-II, interview, police report, and hospital data. The MMPI-II was read only for the substance abuse scales.

The defendant expressed remorse, accepted responsibility for what he had done, admitting to the preparation of ecstasy for personal use and for a friend. His psychiatric history included a hospitalization for depression with

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suicidal potential occurring after his religious community learned of his drug use. He was placed on Zyprexin, Depakote, and Ativan. He subsequently overdosed on alcohol and Ativan. Aftercare for his substance abuse-related problems was recommended, but he did not follow through. He provided the following substance abuse history. At 17, he was using alcohol and marijuana. At 19, he was using LSD with cocaine and also had used over-the-counter cough syrup. He abstained for a period of about a year, but then relapsed when he became anxious and lonely in his life situation. Relapse was on methamphetamine (ecstasy), which he used five times a day for 3 weeks, until he was out of his supply. His most recent use included marijuana about three times a month, alcohol about three times a month, and abuse of Vicodin and Ativan when he could obtain those substances. He uses alone. He described increasing tolerance. He scored high on a drug dependency test. His family history included a maternal grandfather who was an alcoholic and possibly schizophrenic. His diagnosis was polysubstance abuse, and the recommendations were for intensive outpatient therapy after the jail treatment program.

The MMPI-II was reported only for the substance abuse scales. The MacAndrews was not high. The Addiction Admission Scale was at the critical level; the Addiction Potential Scale was not.

Comment. A review of the MMPI-II data that were not considered by the counselor would indicate the presence of an underlying chronic depression, referencing especially the subscales and other special scales that can reflect conditions not obvious on the main clinical scale profile. Scale 2 is at T64, or certainly at a relevant subclinical level. Scales 7 and 8 are clearly elevated. The 278 configuration is a possible indicator of long-term underlying clinical depression. A diagnosis provided by the CD counselor was Polysubstance Dependency but did not reference the Depressive Disorder. Clearly, the treatment program would need to address the underlying depression as well as the psychosocial components that have supported long-term drug use in the face of severe disapproval by significant to the defendant religious and community authorities. His potential for responding to classical drug treatment alone is limited to non-existent. His likely response to a multimodal and multilevel treatment program would be greater.

Case "KL"

KL was a 41-year-old white male. His crime was aggravated possession of drugs, a felony five.

Interview indicated no problems referencing his mental status. He did have significant health conditions of diabetes and hypertension. He indicated that he used alcohol only minimally because of his medical status, although prior to diagnosis, he said he had been drinking two to three beers a day. He

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used marijuana at age 15 to 16 but not since. From age 14 forward, he has been an ongoing two to three packs per day cigarette smoker. He indicated he used cocaine twice and crystal methamphetamine twice. He was prescribed Effexor after his arrest for apparent depressive aspects. He was arrested prior to the current charges for domestic violence, which involved sudden dyscontrol, some pushing, and property damage ("I blew up, broke stuff, and pushed her"). At the time, he said there were serious stressors involving both his children and the death of a highly regarded family member. He had also been through a recent divorce.

His MMPI-II was valid, and the main scale profile was within normal limits. However, the configuration would suggest some primary underlying relational problems. The MacAndrews was clearly elevated, as were the Addiction Potential Scale and the Addiction Admission Scale. Diagnosis was Axis I, Adjustment Disorder with depressive traits, amphetamine abuse, and R/O alcohol abuse; Axis II was deferred; Axis III referenced the diabetes and hypertension. The psychologist noted, on the basis of other records as well as the findings from the tests, that there was likely minimization of his use of methamphetamine. He had a pattern, based on the prior record as well as the present, of admitting only that which had been proved, even when the truth was otherwise. The recommendations included outpatient substance as well as the jail treatment program, and some stress management counseling.

Comment. The pattern of denial is one that has been noted as a marker for addiction. In this case, it does not seem to serve the purposes of denial in methamphetamine cases where a hoped-for minimization or exculpation from legal responsibility is involved. However, his capacity to benefit from treatment, and to avoid relapse into addictive behavior, is clearly imperiled by this mode of operating.

Case "MN"

MN was a 25-year-old African-American male arrested for possession of drugs, felony five, and referred for testimony to mitigate penalty.

Prior criminal history included preparation of drugs for sale, attempted possession of drugs, DUI, probation violations, and other drug-related charges. Social history indicated his father had died as a victim of homicide, but he stated he had never been close to that individual. His mother was employed. He had a history of difficulty beginning in adolescence. He was referred for special schooling because of his inability to conform to classroom expectations, including fighting and truancy. He wound up in the juvenile system on burglary and drug abuse charges and spent the better part of a year in a facility where he received some drug treatment. His employment history was inconsistent with gaps.

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Substance abuse included marijuana every other day to every day, using four to five, unable to stop. He managed to abstain for a year but then returned to regular use. His other dependence was on ecstasy, which he had used every other weekend for a year. He reported using more and more over time. He had tremors, memory loss, and weight loss as a function of that use. He indicated he used cocaine only once.

Psychological assessment was consistent with the substance abuse history and suggested the presence of dependency. Both the MacAndrews and the Addiction Admission Scale were elevated. Other aspects of the MMPI referenced characterologic features including some significant passive–aggressive potential along with antisocial traits. Dependency was reflected on the SASSI-III. Diagnosis based on the data collected was: Axis I: Cannabis Dependency and Amphetamine Dependency; Axis II: Antisocial Personality Disorder.

Recommendations for both jail treatment program and referral to the program with an emphasis on overcoming a criminal lifestyle were made with a suggestion that prognosis at this point may be poor.

Comment. Unfortunately, the above picture is more usual than not. Nonetheless, efforts to find ways to intervene through long-range and multimodal involvements might well significantly reduce levels of criminal activity in the community. However, given a general inclination and "scripting" for antisocial behavior and the profoundly addictive potential of methamphetamine, along with all the other complications it visits upon its users (in this case, probable long-term central nervous system deficits), the poor prognosis is clearly a warranted conclusion from the data.

Conclusions

The foregoing reports are illustrative of the usual processing of individuals who are arrested for methamphetamine, or for that matter, other substance-related crimes. In this particular court system, some psychological attention is provided for persons with drug-related issues, which is certainly not true across the board. Most persons who commit drug-related crimes do not receive any special attention unless they are processed through drug courts, which have begun to develop across the country, or some features of their crimes or situations warrant special attention. It is not uncommon, of course, for persons of means to obtain drug-related assessments and access treatment in lieu of incarceration, but routine forensic assessment of defendants with drug-related issues or crimes is not the usual practice across the country.

However, as this sampling illustrated, when psychological assessment is undertaken, procedures do not regularly address some of the issues that need to be a focus in methamphetamine-related cases. If maximizing rehabilitation is the goal, which would have the benefit of reducing the cost to

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society of addictions-based behavior, the following recommendations can be supported:

- There is a need for neuropsychological assessment if not at the time that these screenings and initial assessments are being accomplished, certainly as part of the initial treatment process. Methamphetamine is known to produce ongoing deficits and disinhibitory potentials.
- There is a need for specific education of both defendants and court personnel about the unique impacts of methamphetamine.
- There is a need for an addictions model, which incorporates a biopsychosocial understanding, as the basis of treatment (see below in the discussion of treatment approaches).

Special Case of Death Penalty Sentencing

As detailed in Chapter 14, sentencing implications exist when methamphetamine ingestion is involved in cases where sanity or diminished capacity issues have been raised. The same can be said for the case of capital sentencing. In all states with the death penalty, there is a bifurcated or two-phase trial process. This format grew out of the resumption of capital punishment that took place in the late 1970s and 1980s. Statutes were written to answer the Supreme Court decision in *Furman v. Georgia* (1972), where it was found that the penalty was levied in an unconstitutionally capricious fashion. Separation of the guilt phase from the sentencing phase was the remedy that developed to answer the questions that had been raised in *Furman* and that pertain to the arbitrary and/or discriminative imposition of justice.

The first phase involves a determination of whether the individual is guilty of an act that has resulted in homicide and whether that act meets certain criteria that define it to be deserving of an extreme punishment. If the jury or, in some cases, judge panel finds the aggravating specifications are supported by the evidence, a second trial takes place. That trial usually occurs a short period of time after the first trial, although it is not uncommon for there to be at least a brief hiatus to allow the defendant and the defense team some opportunity to prepare for the second phase.

Nonetheless, death penalty mitigation work cannot possibly be achieved during the time lapse between the ending of the case in chief and the beginning of the sentencing trial. Therefore, most mitigation preparation takes place during the period before the case in chief is even heard and involves evaluation of the defendant and the gathering of information under the assumption that it may be necessary but with the knowledge that indeed it may not be.

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Methamphetamine, which is known to cause psychotic behavior and also to create the potential for violence, can become a part of a capital case. The issues that have been discussed in other chapters present in full force when it comes to managing an evaluation and presentation to the courts in death penalty cases. In most states, the expert generally works as a member of the defense team. Results of the evaluation come to the attention of the court only with the agreement of the defendant and counsel. The entire process is protected and confidential, which differentiates it from the evaluation that takes place in the case of a sanity or diminished capacity forensic context. In some states, there is provision for an expert to function at the pre-sentence level in a death penalty case and to be appointed by the court to respond to all parties, including both defense and prosecution. In states where there is that possibility, well-informed defense counsel will carefully motion for their own expert rather than accessing a court-appointed independent expert because of the liabilities involved. For the forensic practitioner, the issue is not one of whether it is appropriate to work for defense. It is the duty of the practitioner to represent fairly and honestly and in a scientifically valid way any data that are developed. Sometimes this can mean that the expert does not testify because the results will not be of assistance to counsel who is representing the defendant. Most of the time, however, even in the case of very socially unacceptable characteristics, an expert who explains the defendant and the crime rather than allowing the jury to continue to see the situation only in terms of the highly offensive act that has occurred, provides some basis for a life as opposed to a death outcome.

Two cases illustrate the role that methamphetamine may play in this particular context. In the case of *State of Ohio v. Gary Hughbanks* (1999), an appeals court reviewed the case and upheld the death penalty. The fact picture involved the defendant fatally stabbing a married couple who came upon him as he was burglarizing their home.

Certain aspects of his fairly extended appeal related to the part played by methamphetamine. When Hughbanks was administered the first polygraph test, he produced rather unusual results. The officer asked him whether he had used drugs and he indicated he had been injecting crystal methamphetamine. The officer testified that the findings from the test were consistent with someone coming down from a methamphetamine high, but he also indicated that Hughbanks did not appear to be under the influence of drugs. Hughbanks informed the officer that he had been treated by a psychiatrist; the officer indicated he did not try to talk with that physician. A second polygraph was administered and results did not show any unusual deviations. At issue in the appeal was the notion that results of the tests and the confession obtained should be suppressed because of duress and mental illness factors that affected Hughbanks' capacity to be Mirandized. The officer

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testified that the defendant's behavior did not show abnormality indicative of inability to understand and make the decision whether to cooperate. There was a family history for schizophrenia and there was mental illness history on the part of this defendant including auditory hallucinations, for which he had been admitted to the hospital and prescribed antipsychotic medication.

Hughbanks also appealed on the basis that he should have been provided a neuropharmacologist and substance abuse expert among other professionals to assist in his defense. Certain other objections on the basis of which the appeal was submitted did not relate so directly to mental state and the use of drugs. In the affirmation of his death sentence, the appeals court took the position that the alleged failure to provide necessary funds for experts was without merit since the defendant had made no request for additional assistance at the time. It was noted that he did ask and was granted support for a mitigation specialist and a neuropsychologist.

Although it can be noted that his lack of memory for aspects of the event may have been an artifact of his methamphetamine use and some of the atypical results of the polygraph would not be inconsistent with methamphetamine influence, it is just this kind of situation that raises serious problems around the question of malingering. In one of the errors that he raised, the defendant indicated that his motion to suppress the confession should not have been denied because he was under the influence of drugs when he signed his waiver of *Miranda* rights. He also claimed that he was mentally ill. However, the appeals court took the position that he had not presented any indications that he was functioning on an involuntary basis and that neither his drug use nor his mental state resulted in an inability to voluntarily waive rights. Therefore, his appeal on these bases, as well as others, was not upheld.

An interesting issue also was raised regarding the part played by mental illness. In mitigation to the death penalty in Ohio, mental illness is a statutory mitigator if it results in substantial inability to appreciate the wrongfulness of an act or to conform one's conduct. However, the facts as presented not only did not support a not guilty by reason of insanity plea (which would have been precluded in any event by the voluntary ingestion of an illicit substance), but also did not meet the requirement of inability to appreciate wrongfulness. Thus, this case contained many legal concerns that touch on issues of importance in methamphetamine cases, including neuropsychological impacts, voluntariness given the influence of drugs, and the interaction of drugs and preexisting or potential mental illness. All these factors combined, however, did not rise to the level that allowed the appeals court to reverse the death penalty finding.

Although in the *Hughbanks* case apparently there was reasonable effort made to provide him with representation and with a mitigation defense, the

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same may not be true in many instances. In a 2002 case in Texas involving a man who went on a killing spree following the attack on the World Trade Center, the expeditious and cavalier way of dispensing capital justice seriously contrasts to that which was seen in *Hughbanks*. Stroman was an individual who was apparently in a psychotic state, which was either induced or exacerbated by methamphetamine use. He committed a series of murders based on his belief that foreigners such as his victims needed to die to avenge the 9/11 terrorist attacks. Stroman admitted to the acts and justified them on the basis of his delusional system. The course of the trial, however, is instructive. It took nearly 4 weeks to seat a jury but once that was accomplished, the case in chief began on one morning and was completed in 3 hours. Closing arguments were scheduled for the next day as defense counsel had no witnesses and essentially no defense. The case went to the jury at 10:00 in the morning with a finding of guilty to all specifications by 11:00 A.M. on the same day. The mitigation was scheduled for the next day including impact testimony to be presented by the state. The defense had retained a psychologist to provide mitigation evaluation and testimony and in addition had obtained a neuropsychologist as there was medical evidence of central nervous system damage and a long history of inappropriate behavior. The defendant, incidentally, insisted on coming to his trial dressed in a Harley T-shirt. He maintained his shaved head, which had been his custom for some years, and saw to it that all of his tattoos clearly showed. It was obvious from the outset that he would join the ranks of many others in Texas where the speedy administration of capital justice is the rule and the niceties of defendant rights may be observed in the breach. The jury returned in 5 hours with a recommendation of death (Mary Connell, personal communication, March 2002).

Treatment as a Sentencing Consideration

Although substance abuse in general and methamphetamine abuse in particular have given rise to sentencing enhancement rather than leading to a primary focus on recidivism prevention, the importance of intervention has not been lost in the criminal justice system. Toward that end, as was seen in the review of court cases above, recommendations for treatment as part of probation or conditional release are not uncommon. However, reaching a goal of reducing addictive behavior and the crime that is associated with it depends on having adequate treatment modalities.

Treatment for chemical dependency in general and specifically for methamphetamine has not been uniform around the country. There have been a number of attempts through the National Institute on Drug Abuse (NIDA)

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and American Society for Addiction Medicine (ASAM) to develop standardized treatment protocols that would act as guidelines to programs that treat addiction. However, the penetration of these algorithms in the provider community has been at best sporadic and fragmented. Many providers continue to use a traditional approach to treatment that is primarily based on the disease concept and follows the Hazleton model. This approach, although effective for many, is more than 30 years old and it has not integrated some of the more recent scientific understanding of addiction and addiction treatment. There continues to be a primary substance-based understanding of addiction as opposed to a more complex model.

A more modern, scientific approach considers addiction as a disorder of activation. Based on this model, there are genetic predispositions to addiction. Those who begin to use mood altering substances activate the addictive tendencies. With frequent and chronic use this pattern becomes solidified and can create major changes in the brain chemistry and the way in which the individual responds to non-drug-induced pleasurable stimuli. The addict will require mood-altering substances to activate certain processes in the brain in order to experience pleasure. With chronic use, there is a shift from attempting to create pleasure (the high), to avoidance of pain, which is caused by withdrawing from the substance. To avoid pain the addict will use whatever means necessary to obtain drugs and the compulsion to use will control multiple aspects of his or her life. Prolonged drug use will affect the physical, social, and psychological functioning of the addict and will result in a downward spiral. The addicted individual who is fortunate enough will "hit bottom" before causing permanent destruction in his or her life; compelled by a sense of desperation, along with external pressures (such as the carrot and stick of court-mandated treatment), the addict may then seek help.

There is a great deal of variability in addiction treatment around the country. If a treatment program is part of a larger behavioral health provider, it is highly likely that it provides a wider range of services than is found as part of a general hospital setting. Such multifactor programs include detoxification and some form of rehabilitation above and beyond simple discharge into a 12-step community-based program.

Comprehensive addiction treatment needs to be multidimensional. This approach to treatment can be highly effective but it tends to be more costly than the more traditional interventions. Because prolonged addiction can create problems in a number of areas, treatment planning needs to consider the various aspects of the individual's adjustment that are affected. A multilayered approach, which allows intervention into physical, social, psychological, and psychiatric problem areas in individually tailored fashion, is necessary.

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In the ideal situation, the addict is followed through varying levels of care in the same organization and there is familiarity with the case. However, effective communication between agencies with a consistent treatment philosophy can achieve the same result.

The most acute level of care in addiction treatment is medical detoxification. During this phase the addict is abstinent from drugs of dependency and a state of withdrawal will ensue that must be medically managed. Treatment during this phase often requires medication that reduces withdrawal symptoms by acting on the brain in similar ways as did the substance of abuse. These medications are generally slow-acting substances and do not result in drastic changes in mood.

For most substances, the acute phase of this process lasts less than 4 days. However, there are certain mood-altering substances that tend to have longer-lasting half-lives and can continue to create discomfort and problems associated with withdrawal. Heavy methamphetamine use can result in prolonged chronic withdrawal symptoms, which are physiologically based but psychologically expressed, including anxiety, irritability, and anhedonia (loss of pleasure in life). Sometimes, there is progression to a major depressive state.

Care during acute and early chronic withdrawal involves an extensive medical assessment as many addicts have a history of neglecting their health and often suffer from a variety of health-related problems secondary to their drug use and the lifestyle associated with a drug-abusing subculture. Often addicts, particularly those with an extensive history of alcohol use (and most methamphetamine users are polysubstance abusers with alcohol a frequent component), suffer from malnutrition and medical problems related to vitamin and nutritional deficiency.

Shortly after the detoxification is completed, addiction treatment for most patients can be provided on an outpatient basis. Day treatment and intensive outpatient programs are options that are often used. A subpopulation of patients with coexisting mental health diagnoses may require a more structured treatment immediately after detoxification. A large-scale internationally based study of specific interventions into methamphetamine-induced psychoses is currently in the process of development. The researchers hope to identify the best neuroleptic medications as well as other treatment and prevention components (J. Rathner, personal communication, June 2002). An adequate treatment program needs to consider external problems in areas of work environment, neighborhood, and family that can create significant problems in recovery. While dealing with relapse is part of a modern treatment program, with addicts who have had repeated relapses after detoxification, more structured and highly supervised modes are indicated. Where individuals have co-morbid psychiatric diagnoses, high levels

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of family conflict, or have high levels of external cues that trigger addictive behavior, treatment-planning teams need to consider a clinically managed residential program with step down available to a more traditional residential program.

The clinically managed residential program is particularly effective with individuals who require psychotropic medications. Often, extensive education and orientation are indicated to prevent dropout from treatment and early termination of medication use.

Long-term therapeutic communities that focus on providing structure, supervision, treatment, and resocialization can be effective in treatment of the more chronic group of individuals who have had a history of difficulties with issues other than addiction. Some communities have developed and implemented prerelease programs for addicts who have been incarcerated for nonviolent drug-related offenses. These programs are designed for those addicts who are highly vulnerable to relapse and require a high degree of external support and structure.

In these programs, the addict is usually provided with incrementally higher levels of responsibility and moves along the continuum of being closely monitored to rather independent living and working in the community. However, these programs usually have limited direct treatment modules such as group or individual therapy. They rely heavily on peer support and use other community resources for treatment of adjustment difficulties that are often present in addicts who are new in recovery. The length of stay in this type of program is relatively high and can range from 90 to 180 days. It is hoped that with the routines that are established during their stay in such programs, addicts will begin to internalize a more structured lifestyle that is conducive to staying sober. In most of these programs there are daily requirements and each resident is mandated to attend 12-step groups.

Short-term residential programs, on the other hand, are designed to integrate the addict into the recovering community (Hubbard et al., 1998). During their stay in these programs, clinical staff and peer support focus on helping addicts develop internal coping skills that enable them to live a sober lifestyle. Participants also are presented with alternative approaches to asking for peer support in 12-step recovery meetings and to expand their sober social support systems. Learning leisure activities that are conducive to staying sober is included to assist in prevention of relapse through avoidance of old "traps."

Generally speaking, an essential aspect of recovery from addiction is active participation in 12-step recovery programs. This process, which includes extensive peer support and following the tradition of using 12 steps in the recovery process, has proved to be relatively effective in promoting and maintaining abstinence in alcoholics and addicts. There is limited

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scientific scrutiny of the program as it is, by nature, an anonymous group and it does not easily lend itself to empirical investigation. However, intuitively, the values of the 12-step programs are in the structure that they provide for the addict. This type of external sober support is instrumental in relapse prevention and takes the addict out of situations that contain cues that activate drug-seeking desires in the brain and subsequently lead to use.

Effective addiction treatment requires a multidisciplinary team. To be able to perform a comprehensive biopsychosocial assessment of the addict, the team needs to include a physician (an addictionologist or a psychiatrist with addiction treatment specialization), a psychologist, and a chemical dependency counselor. Clinical social workers who provide family and social assessment are essential team members. For treatment to produce optimal results, these professionals must collect data and work together in treatment planning. An attitude of respect for the participant includes an understanding on the part of the treatment team that addicts, like all other patients, are interested in getting better (Demiff et al., 2000).

In order for a substance to affect an individual's mood, it must be able to pass the blood–brain barrier and cause biochemical changes in the brain. The cognitive, emotional, and behavioral effects of these substances mimic those seen in other processes that result from changes in brain chemistry, such as mental illness. It is common that during the active phase of their use, methamphetamine addicts in particular may be diagnosed erroneously as suffering from mental illness. Evaluation must proceed with care or an individual who is abusing substances or addicted to them could be diagnosed with an illness that is chemically induced and may disappear when direct effects of the chemicals dissipate. Kono et al. (2001), in their comparison of individuals who abused nicotine, alcohol, methamphetamines, and inhalants, noted that those who abused methamphetamines displayed a significantly higher intensity of symptoms related to perceptual disturbances, thought disorder, mood disorder, and problems with acting out behaviors, which they categorized as volition disorder.

On the other hand, it is very important to note that there are those addicts or alcoholics who have a coexisting psychiatric condition (patients with dual diagnosis). For individuals who display psychiatric symptoms as a side effect of their substance abuse, there needs to be an active treatment plan for addiction treatment, and a "wait and see" approach toward the psychiatric symptoms. Those individuals who either have a preexisting psychiatric condition or who have developed psychiatric illness during the course of their use of mood-altering chemicals will require a treatment plan that includes psychiatric interventions. Unfortunately, many traditional addiction treatment programs around the country lack appropriate psychiatric services, and this aspect of treatment for those addicts who are most vulnerable is missing.

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The usual pattern noted in treatment of these individuals is characterized by repeated relapses and the psychiatric symptoms interfering with ability to benefit from the addiction recovery program. Also, shortly after discharge from these programs, the individual is likely to go back to using drugs in an attempt to self-medicate the psychiatric symptoms. Dual diagnosis treatment needs to be provided by a team of professionals who have expertise for both addiction and psychiatric problems.

The opposite case can also occur. There are psychiatric programs that mistakenly attribute drug-related symptoms to psychiatric conditions and often attempt to medicate the addiction problems away. Ignoring addiction-related issues not uncommonly can lead to prescription of addictive medications for what are withdrawal symptoms.

One of the main problems in the field of addiction treatment is blaming treatment failure on the patient with accusations of "poor motivation" and "being in denial." In making these statements, the clinicians absolve themselves from any responsibility for providing the type of care that is a "good fit" for the patient and thus lose a chance to improve compliance levels. Also, in blaming the patient for treatment failure, a cyclical reward system is set up that promotes the sense of inadequacy and low self-esteem often associated with being an addict. The patient is invalidated and the problem is increased. In research with patients suffering from borderline personality disorder and other patient groups with multiple problems, Linehan (1993) has demonstrated that validation is an effective tool for engaging patients in treatment and therefore obtaining more positive outcomes. The tradition of pejorative labels for patients who have difficulties in navigating a course of treatment has been a significant factor in addiction treatment failures. (For example, a counselor dismissing a patient as a "frequent flyer" is not unknown in the case of so-called resistant participants.) If the patient accepts the view of the counselor, then he or she has incorporated a concept of inability to benefit from treatment. If, on the other hand, the patient disagrees with the assumptions of the counselor, then there is demonstrated "noncompliance," which can lead to termination of treatment (so-called therapeutic discharge).

In treatment planning for addicts it is important that those who provide the treatment take some responsibility for making sure that the addict is motivated to follow the treatment plan. There are certain commitment strategies that can be quite effective in raising levels of participation. Linehan and colleagues (Linehan, 1993) have demonstrated the effectiveness of these strategies in keeping patients with borderline personality disorder engaged in treatment. Treatment dropout can be reduced dramatically when commitment to therapy is defined as a major objective of therapeutic work rather than as a prerequisite on the part of the patient. Thinking about treatment

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in this way is especially necessary for individuals who have been referred into treatment by the legal system, rather than presenting themselves for assistance.

Completing a comprehensive program is enhanced through evaluation of prior treatment history. The addict must be asked to outline a history of addiction and psychiatric treatment including the reasons for admission to treatment, the center where treatment occurred, the length of treatment, how long sobriety lasted, and what caused the relapse. A great deal of insight can be obtained if further questions on the course of treatment and its completeness are assessed. As mentioned earlier, there is a great deal of variability in how addiction services are provided; however, there are types of treatment that tend to be offered by certain programs and attended by certain types of addicts in order to pacify certain individuals or institutions. For example, in cases of driving under the influence, many individuals, especially first-time offenders, participate in a weekend program that takes place at a local hotel. Educational offerings are the main aspect of this intervention, along with the brief isolation. There are also many individuals who enter a treatment program and are in the process of withdrawal from drugs and alcohol. These individuals are usually detoxified medically, and are presented with certain educational modules regarding alcoholism and addiction. The assumption is made that these addicts can manage the cognitive tasks involved. After a few short days, they are discharged into the community with no meaningful follow-up treatment and are told that they are in a place where they can benefit from community-based 12-step programs.

Therefore, it is important that during the assessment period, questions regarding the extent and type of treatment are asked to determine whether or not the addict has had a true chance at recovery. Issues related to the type of professional involved in treatment and the programmatic aspect of treatment need to be addressed. This aspect of assessment is even more important in forensic situations, because addicts with legal involvement and criminal convictions tend to have fewer financial resources and it is likely that their treatment was provided in community-based agencies that also have limited resources. It also allows some education of the court regarding those factors that were not under the control of the individual and that favor appropriate treatment options.

Given the extensive damage caused by even short-term use of methamphetamines, the issue of deficits associated with brain injury needs to be addressed directly. Certain aspects of this type of deficit clearly interfere with the addict's ability to learn and process information. A great deal of programming at most addiction recovery centers is based on a psychoeducation model. It would be safe to assume that chronic methamphetamine users may have a great deal more difficulty with the learning material presented to them than persons without the central nervous system damage. Given that impulse

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control and inhibition and management of feelings are difficult for these individuals, frustration enhances dropout potentials as well as leads to acting out in ways that disrupt treatment for themselves or others. If cognitive deficits that result in significant interference with learning are noted, appropriate assessment should be undertaken. It may be important to design treatment interventions that are behavioral in nature and do not involve higher-level cognitive work. At the same time, cognitive rehabilitation measures can be included in the treatment plan that will assist in later mastery of more traditional educative aspects. In fact, the 12-step recovery program has a strong behavioral component that is designed to engage participants in the process even if they do not cognitively appreciate more abstract principles.

Educating the addict's support system can positively affect treatment outcome. Family members, sponsors from 12-step programs, probation officers, and case managers should be informed about the complexities related to how the brain of the addict may be compromised. As a result, the addict's support system is less likely to engage in blaming — and thus unwittingly contribute to treatment failure when cognitive interference leads into treatment lapse.

Individuals with dual diagnosis are significantly more difficult to treat and tend to have a higher rate of relapse in both their psychiatric condition and addiction. This phenomenon generally arises because one or the other aspect of their condition is not treated adequately. As mentioned above, there are major psychological issues and cognitive deficits associated with methamphetamine use. In addition, behavioral problems, often secondary to either premorbid personality or brain damage caused by the destructive force of the substance, make management of these individuals difficult in traditional treatment settings.

The dual diagnosis problem should be assessed prior to making a referral for treatment. Individuals with a history of methamphetamine use and other coexisting conditions require an addiction treatment facility with significant capability to address psychological and psychiatric issues. This combination of expertise is rarely present in even fairly sophisticated treatment settings and is conspicuously absent in programs designed for "treatment" of addicts who have been adjudicated and have been mandated to receive addiction treatment programming as part of their sentencing.

Prerelease programs usually run between 90 to 180 days and are designed to assess the individual's capabilities to live a sober life outside of the structure of a correctional facility. These programs are not designed to provide primary treatment of any type and are often managed by graduated peers. They are usually found in inner-city locations with access to drug-infested neighborhoods. Given the cognitive, emotional, and behavioral vulnerabilities of chronic methamphetamine users, these programs can represent a major risk

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for "treatment failure" with subsequent categorization as resistant or noncompliant.

Another aspect of treatment for methamphetamine users is related to how rapidly they become addicted to this drug and how quickly their use results in major impairment and subsequent need for treatment (Castro et al., 2000). Hartz et al. (2001) have reported extensively on the intensity of craving for this drug and the cues associated with relapse because of it. In the long run, the emphasis needs to be on prevention because the prognosis for methamphetamine-addicted individuals, given the brain impacts, can be bleak.

Review of Treatment Center Cases

Some of the above observations regarding treatment can be seen in the case characteristics found in a review of methamphetamine cases from a relatively small suburban multimodal psychiatric facility located in northeast Ohio. Laurelwood is a private facility that is part of the larger community of healthcare institutions known as University Hospitals.

Laurelwood has a largely working- or middle-class population with insurance coverage or the capacity to pay for treatment, although *pro bono* service is offered when feasible. As such, the case sample is not representative of the nation at large insofar as drug abuse patterns and responses to treatment are concerned. Given the population skew, the following results from this case survey raise some red flags in spite of the small sample size.

Procedure

Cases admitted to the hospital during the past year were reviewed to obtain a selection where methamphetamine abuse was present; 17 cases were identified (Table 11.3). Information collected included gender, marital status, age, other substances abused, criminal record including arrest, time served, and probation, chemical dependency treatment history, mental health treatment history, presence of agreement for treatment after release, Axis I diagnosis, Axis II diagnosis, Axis III diagnosis, family history for chemical dependency

Table 11.3 Demographic Characteristics

Gender		Mean Age	Age Range	Marital Status				Total
				Single	M	Div	Sep	
M	$N = 13$	24.85	18–40	10 (77%)	1 (8%)	1 (8%)	1 (8%)	13
F	$N = 4$	26.75	16–39	2 (50%)	2 (50%)	0	0	4

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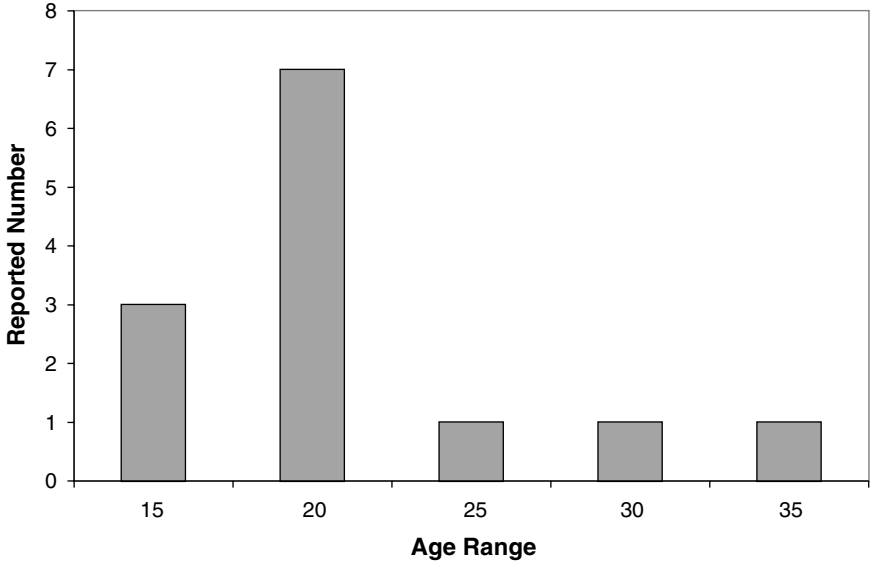

Figure 11.1 Onset of methamphetamine use.

Table 11.4 Reported Criminal Justice Contact (*N*,%)

Gender	Arrest History	Served Time	Probation
M	8 (47%)	5 (29%)	1 (6%)
F	2 (12%)	1 (6%)	0
Total	10 (59%)	6 (35%)	1 (6%)

or other mental health diagnoses. No identifying information was reported and data have been grouped as indicated below.

Results

This small sample, heavily weighted with males over females, nonetheless has characteristics of significant interest. The age range includes persons who are into middle life years. However, as Figure 11.1 shows, the period of most likely initial use is in the 20s for the 13 states where information about the initial use of methamphetamine was available.

Table 11.4 illustrates the not surprising finding that over half of the sample reported contact with the criminal justice system. Of the 11 patients for whom there was a report of involvement with the criminal justice system, several kinds of offenses were referenced. Of the 11, 9 had at least one charge that involved substance-related activity (possession of drugs or paraphernalia, driving under the influence, under-age consumption). Five had contact

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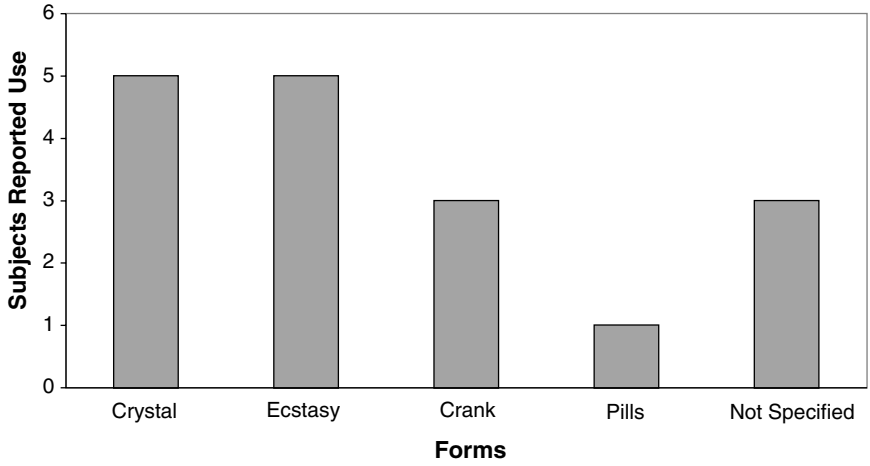

Figure 11.2 Forms of methamphetamine used.

with the criminal justice system secondary to aggressive behavior including domestic violence, disruptive behavior in school, assault charges, and attempted murder.

Table 11.5 clearly illustrates the polysubstance use patterns of this sample, which are characteristic across the board in treatment centers such as this. Alcohol, as might be expected, remains the most likely substance to be abused in addition to other identified chemicals and was found in every one of these methamphetamine users.

Table 11.6 illustrates another facet of the diagnosis and treatment of chemical abuse. There are significant co-morbid conditions; some are induced by the substance abuse but others are preexisting or co-occurring and may themselves be underlying bases for drug/alcohol involvement. Given the short inpatient treatment scope in this setting, most Axis II diagnoses were deferred with only one person identified as having no Axis II vulnerability and only two positively identified with a personality disorder.

Figure 11.2 illustrates the prominence of ecstasy as one of the more important manifestations of methamphetamine abuse in this region.

Other data collected on this sample included information on Axis III conditions: hypothermia, sexually transmitted diseases (STDs), possible lupus, chronic pain, chronic obstructive pulmonary disease, arthritis, possible malnutrition, and asthma. Family history was positive for significant mental health conditions in three records (bipolar affective disorder, schizophrenia, and Alzheimer's) and was significant for alcohol abuse or dependency in 14 of the cases.

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Table 11.5 Substance Abuse Status (*N*,%)

Sex	ETOH	Cocaine	Marijuana	Hallucin	BZPs	Narcotic	Other
M	13(76%)	11(65%)	11(65%)	8(47%)	2(12%)	7(41%)	Inhalent, nicotine, oxydone
F	4(24%)	4(24%)	3(18%)	4(24%)	0	2(12%)	Nicotine, barbiturates, ketamine, Vicodan
Total	17(100%)	15(88%)	14(82%)	12(71%)	2(12%)	9(53%)	

Note: Percentages not exact sums due to rounding errors.

Table 11.6 Axis I Diagnostic Status (*N*, %)[a]

Sex	Non-Substance-Induced Mood Disorders	Substance-Induced Mood Disorders	Non-Substance-Induced Psychotic Disorders	Substance-Induced Psychotic Disorders	Adjustment Disorders	ADHD	Other
M	2(12%)	1(8%)	2(12%)	2(12%)	2(12%)	2(12%)	Substance Induced (1)
F	3(18%)	2(12%)	0	0	0	0	Oppositional Defiance (1) Anorexia Nervosa
Total[b]	5(29%)	3(18%)	2(12%)	2(12%)	2(12%)	2(12%)	

[a] Rule outs were assumed to be present, consistent with DSM-IV system and were counted. They included one major depression, one substance-induced mood disorder, and one adjustment disorder.

[b] Patients had more than one Axis I condition; numbers do not sum to 17.

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Discussion

The fact that methamphetamine cases were relatively uncommon for this population does not diminish the importance of the findings. In effect, there is an early indication of an increasing problem, which is seen in the small sample available for scrutiny. The characteristics of these individuals and their families were consistent with what is repeatedly found in all other areas of substance abuse. There is a family component. Involvement with illicit substances places one at risk for criminal justice contact, and there is a significant likelihood of mental health co-morbidity of a type that requires that the treatment plan include appropriate components. Clearly, this is not a population that can be served by a one-size-fits-all treatment approach, nor is it a population that can be treated in any setting where all use of substances, including psychotropic medication, is not well tolerated. Recent media exposure has featured reports of ecstasy abuse, which has become one of the more common party drugs in the geographic area served by the hospital. The findings of this small study are consistent with alarms that have been raised about the use of this significantly dangerous substance.

Resources for the Sentencing Process

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2001) provides a directory with listings for type of services available at facilities across the country which is issued on a yearly basis. Identified service categories include indication of those programs that are set up to provide for the criminal justice population. A brief phone survey of some of these facilities was initiated using a semistructured inquiry was conducted (see Appendix I). Even given the very limited number of contacts with completed data (N = 20), there was geographic representation across the mainland. Assuming the sample to have some representatives for the national picture, it would appear that there is increasing use being made of cognitive behavioral approaches, often in combination with 12-step programs. Multiservice was the rule. Most had some psychiatric care and almost all indicated dual diagnosis treatment was offered including psychotropic medication. (However, one informant indicated dual diagnosis patients were treated, but also stated no one was allowed to have prescribed medication once the individual entered the program.)

All facilities had social work coverage, about half had psychologists All either had detox units or could access the service. Almost all either had or accessed inpatient, partial hospitalization, or intensive outpatient programs. Almost half had a residential program in place. Ancillary programs, such as occupational and recreational therapy and vocational rehabilitation, were

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also seen as important components in treatment planning (N = 18, 90%). In a couple of contacts, there was unwillingness to respond to questions about the scope of services and underlying treatment philosophy and there was one facility where no one claimed to know the answers to the questions. On the other hand, there are settings that include specific methamphetamine focus, such as the UCLA Integrated Substance Abuse Program (Cunningham–Rathner, personal communication, June 2002). Clearly, it becomes important to engage in direct person-to-person contact in making referrals.

Chapter Summary

Substance abuse has become a complicating factor at all levels of the American criminal justice system. In the particular case of methamphetamine, use has generated a body of case law and led to specifications in the federal sentencing system. At the state level, it has been incorporated in various ways into sentencing considerations. Forensic assessment has proceeded from a psychological perspective of understanding behavior and designing interventions. The sometimes difficult interface between mental health and law is regularly evident in forensic assessment around methamphetamine cases and particularly in regard to the sentencing process. Issues of risk analysis with its inherent insecurities and yet its important place in supporting the protection of society as well as the rights of the individual have clearly been a part of the processing of methamphetamine cases. While some varieties of substance abuse affect primarily the individual insofar as negative outcomes are concerned, methamphetamine is a drug that is regularly associated with disinhibition and violence. The reduction of violent crime is of high concern to law enforcement and the overall operation of justice. As with all others who seek to serve the best interests of the system of criminal justice, it is necessary to walk a tightrope. This balancing act must take place within the scientific limitations of the data collected, further complexly constraining the practitioner.

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